EMERGENCY MEDICAL SERVICES ADVISORY COMMITTEE

Ameritel Spectrum, 7499 Overland Rd., Boise, *ID*

September 30, 2004

COMMITTEE MEMBER ATTENDEES:

Vicki Armbruster, Volunteer Third Service Member
Ken Bramwell, Emergency Pediatric Medicine
David Christensen, Idaho Chapter of the American Academy of Pediatricians
Jeff Furner, Career Third Service Member
Kallin Gordon, EMT-Basic Member
Leonard Harlig, Consumer Member
Pam Humphrey, Air Medical Member
Mary Ellen Kelly, State Board of Nursing Member
Karen Kellie, Idaho Hospital Association Member
David Kim, Idaho Chapter of ACEP Member
James Kozak, EMT-Paramedic Member
Robert D Larsen, Private Agency Member
Scott Long, Idaho Fire Chiefs Association Member
Cindy Marx, Third Service Non-Transport Member
Murry Sturkie, DO, Idaho Medical Association Member

COMMITTEE MEMBERS ABSENT:

Hal Gamett, Fire Department Based Non Transport Member
Warren Larson, EMS Instructor Member
Mary Leonard, State Board of Medicine Member
Ethel Peck, Idaho Association of Counties Member

VACANT MEMBER SEATS

ID Chapter of ACS Member, Committee on Trauma
County EMS Administrator
Advanced EMT Member

EMS STAFF ATTENDEES:

Kathy Bessey
Tricia Burns
Larry Carmona
Doug Carrell
John Cramer
Brandi Creamer
Andy Edgar
Barbara Freeman
Dia Gainor
Scott Gruwell
Shana Munroe
Dean Neufeld
Tawni Newton
John Sanders

Other Attendees:

Allen, Tom - Nampa Fire Department
Day, Michael -
McCoy, Carrie -
McCulley, Kathi
McKinnon, Debra - Latah County EMS
Murphy, K.C.
Owen, Greg - Canyon County Ambulance District
Rose, Stan - Life Flight (St. Alphonsus)
Sandy, Curtis - Portneuf Life Flight
Schwab, Greg - Ketchum Fire
Sharp, Lynette - Air Idaho Rescue
Vickers, Greg - Portneuf Life Flight
Weiss, Joe - East Boise County Amb District
Weiss, Phyllis – East Boise County Amb District

Discussion	Motions/Recommendations
MINUTES	Approved.
NEW BUREAU MEMBERS Doug Carrell in Regional Operations. Larry Carmona SW regional consultant. John Sanders in EMSC.	
HOUSEKEEPING Ethel Peck, Bob Larsen, David Kim have been reappointed.	Meeting Schedule: December 8 & 9, 2005 March 9 & 10, 2005 June 29 & 30, 2005 Sept 21 & 22, 2005 Dec 7 & 8, 2005
NATIONAL EMS SCOPE OF PRACTICE MODEL PROJECT	
We have used the National Standard Curriculum for every level in Idaho. NHTSA has announced it will not produce another national standard curriculum. What are we going to do? The EMT-B course is already 10 years old. National EMS Education Agenda for the Future was created 3 years ago. Why did NHTSA stop? Many voices told them they should not be writing prescriptive curriculum. Revisions to curriculum were inappropriately driving changes to scope of practice. A better approach is to manage a core content on a periodic basis and then develop a corresponding scope of practice (what is necessary). Once defined, the Education Standards can be written. NHTSA responded to the National EMS Education Agenda for the Future. NHTSA funded the National core content project and devised a scope of practice approach. The first draft is out and the task force is calling for comments until Jan 2005. National certification and program accreditation will be the most challenging. Dia described the scope of practice. There has not been a national EMS education system or master plan. Skills and education will be based on perceived need of patients. Dilemmas: • No EMS career ladders, especially across state lines. • Isolated frame of mind that the only way we know to assist a patient's entry into the health care system is through the ER.	

The major changes are:

- New names. (Currently the names of EMS provider levels vary from state to state. There are 44 different EMT-I designations nationally. Intermediate is not on the proposed list. There cannot be an intermediate level on a national level because of unique needs.
- Interventions allowed for the various levels are described. Every level encompasses previous level.

The Project is asking for comments submission to these questions.

1. Is a common titling system preferable to individual name for each level of provider?
2. Are the proposed names descriptive and useful for public understanding?
3. Do the proposed names describe a progression of the professional preparation associated with each level?
4. Are four levels appropriate? More or less?
5. If an additional level were created and placed between the proposed EMR and EMT, which skills should be included at each level? (Rationale about the EMT level. Unless the EMT is identical to the current EMT, a conversion would too large of a workload. Compare the new scope of practice to answer the questions.)
6. Is there a need for a level more than a paramedic?
7. Feasible for the health care education system to meet anticipated needs?
8. Will physicians be willing to provide medical direction?
9. Can reimbursement for this level of provider be commensurate with services provided?

Dia discussed reimbursement unknowns, policies, and intervention highlights.

Strategy: Is it better for the EMT to do some higher end skills or to maintain the EMT as a low cost, easy access entry level provider with a training progression to another level.

The Paramedic level has relatively few changes.

Advanced practice paramedic will be more independent than current levels. Akin to PAs. Reviewed intervention highlights of the advanced practice paramedic.

Questions: 1. Are the skills descriptions reasonable and appropriate? 2. Will the increased training for the EMR and EMT be feasible? 3. Is the education required for the advanced practiced paramedic level reasonable? Is it fiscally feasible? Manpower? Will the public understand? Will other health care workers support the new model? Timelines: Open for comment until Jan 2005. National Review Team will meet in Spring 2005. Final document due to NHTSA by 9/2005. PLEASE COMMENT! DISTRIBUTE TO OTHERS! www.emsscopeofpractice.org Comments will be weighted according to submitter category (i.e. comments from national associations will carry more weight than state association and so on.) Once the model is established, there will not be a National Registry or other support for unique levels outside of the model. EMSAC member comments: What provider would receive training like primary care, immunizations, home, pool, elderly safety? Immunizations – advanced. Safety – EMT. Concept of EMS based health care. Advanced care in the rural setting. Integrate the provider with the health care system. Add a fifth level, EMT with additional skills such as IV intervention to fill void in the rural area. Proposal that EMT should be able to start an IV. Seems to be a gape between EMT and paramedic. What about critical care provider? Deal with core and specialty content separately. EMT-I will become EMT-Idaho. Skills sets unique to our geography. Downside: Buy our own exam, create own textbooks or modify existing textbooks. Will other states have the same rural issues? Will there be jobs for the advanced practice paramedics? Shouldn't we focus on saving lives in emergency situations? APP not intended to be primary care provider. In response to a question about reimbursement entities, Dia stated that third party payers will be sitting on the review board. What about maintenance of skills? What's a reasonable course length to make it attractive for people to pursue?	Recommendation made for EMSAC to submit a consensus document based on the proposed Scope of Practice draft prior to Jan 30 deadline. EMS Bureau willing to facilitate meeting during next EMSAC meeting. EMSAC Members/interested Idaho EMS system members should send written comments to EMS Bureau. EMS Bureau then create draft of common concerns and recommendations prior to next EMSAC to start with at that meeting. Mail copy of SOP draft to medical directors with cover letter asking for written comment also.
TRAINING SURVEY RESULTS	Postponed to next meeting.

AIR MEDICAL CRITERIA TASK FORCE UPDATE – TRICIA BURNS	
John O'Hagan elected chair. First meeting consisted of housekeeping and administrative issues. Using the Model Air Dispatch Guidelines as a template. Systematically going through the headings answering high level questions and then going through the headings in more depth. The next meeting will contain a Rules 101 session to focus on our piece in the context of existing rules. Will be able to share a draft at the December meeting.	
MUTUAL AID – DOUG CARRELL	
Bureau has been assisting health districts and HRSA funding bioterrorism projects. One of the benchmarks is EMS Mutual Aid. EMS is participating in the development of a planning guide. Purpose is to assist agencies to assess their current mutual aid programs and/or in developing additional mutual aid agreements. Distributed draft and asked for feedback. Assess content in the draft by emailing or calling the Bureau.	
EMSAC MEMBER CONCERN	
Leonard Harlig: Political problem in Blaine county that may affect the EMS system. Conflict of interest. Firefighter serving on city council may be construed as engaging in fraudulent and illegal activity. Concern is that if a legal precedent is set, small communities may be affected. Might need to make recommendations to the Legislature. The city attorney has been asked to bring criminal charges.	
AIR MEDICAL SUBCOMMITTEE REPORT	
Key Points • Notification Policy document now includes weather shopping statement • Rotation is not included in the document • Discussion regarding the number of flight following phone calls made to StateComm during a flight Identified future agenda items	Motion to accept the subcommittee report was seconded and carried.
DISCIPLINARY SUB-COMMITTEE	
Key Points • FYI only-initial complaint regarding provider who completed EMT course but did not test. Provider responding to calls and representing himself as EMT. Information requested from complainant for further follow up.	

Discussion How do the involved agencies find out about the recommendation? Bureau has to make a decision about the recommendation. The involved agency will receive information about that decision. Does the state have a resource for drug testing? There is not an established process like the Board of Nursing or BOM for impaired providers. The Bureau has selected drug testing as a certificate action, but doesn't have a standing program either on an entry level basis or voluntary or post employment. Shouldn't there be some guidelines for the agencies about drug testing? Maybe a national organization might have a model? Department of Transportation has a program. Canyon County Paramedics offered to share their guidelines.	
TRAC- JOHN CRAMER	
Presented the history starting with S1145 (2001) which resulted in S1319 (2002) and the creation of Title 57, Chapter 20 and the Trauma Registry Advisory Committee (TRAC). Need for collecting data. TRAC focused on definition, design, funding, and implementation processes. Consensus on data definitions, inclusion criteria and data elements. Data linkage with hospitals, EMS PCRs, OHS crash data, death records from Vital Stats. Technical requirements were used to send out a RFI (request for information). These will again be used for purchase specifications for the soon to be released RFP (request for proposal). The system will be Internet based. Funding has been identified. Revenues from vehicle registrations and driver's license have increased in excess of budgetary allocations That gap was enough to fund the registry. The 103 data elements plus calculated fields total 125 data elements. Data linkage is the key to the registry. Currently in the RFP phase. A task force is working on a requirements process. RFP will be ready to submit by Nov 24, 2004 to DHW purchasing. Prescribed DHW process will take about 4 months. Anticipate awarding contract on April 1, 2005. Effective implementation July 1, 2005. Question about the funding from dedicated funds. Isn't the funding dedicated to equipment and vehicle grants? That is the dedicated III fund. TRAC will be funded from dedicated I & II	Motion to accept the report seconded and carried. Request for an annual report on the registry progress.
EMSC	
Ken Bramwell elected new chair. Thanks to David Christensen for his work as chair.	

Key Points • Last sponsored PPC course to be Dec 3-4 • Most or all PPC instructors will be qualified • Infrastructure built to ensure quality program • Award program is being developed • Old plan updated • Goals & Objectives re-aligned • Performance Measures included • Goal completion time-lines identified **Discussion** Discussed importance of database for special-health care needs pediatric patients. What can providers do when there is child neglect or abuse? Obligated to report. Call 311 – Child Protective Services. Information about reporting is on the idahoems.org website.	**Subcommittee Recommendation** Recommended continuing efforts in developing a state-wide electronic database that will communicate special-health care needs to pre-hospital professionals. **General Session Discussion** Motion to accept report was seconded and carried.
MEMBERSHIP TASK FORCE	
Key Points • Leonard Harlig acting chair for this meeting due to the absence of Dr Sturkie. • Draft EMSAC Policy/Procedure manual reviewed. • Modified Roberts Rules of Order to be added with meeting decorum standards. • Discussion of sub committee membership and voting authority. Current practices of other standard models reviewed. Standard already being used in the Medical Direction sub committee presented by Andy Edgar. Consider policy needed to address possible fiscal impact of ad hoc members **Discussion** Voting recommendation. What would happen to the medical direction subcommittee if physicians only have one vote? The EMSAC chair and bureau will give prior approval for member/ad hoc variations. Are you referring to those occasions when people are self selecting and attending meetings as opposed to when the Bureau invites an expert ad hoc member? Yes, desire to differentiate. Two kinds of sub-committee members who can vote: • Appointed by DHW, and • Approved and invited ad hoc members. In this recommendation the chair of the subcommittee, chair of EMSAC, and EMS bureau representative are the approvers.	**Subcommittee Recommendation**: For open sub committee meetings (excludes disciplinary and licensure) the chair, the EMSAC chair, and assigned bureau representative will have the authority to determine necessary ad hoc members. The sub committee may then identify needed representation and the selection process to be used, and notify EMSAC full committee of the selection process and ad hoc members selected. Ad hoc members will have full voting authority in their designated subcommittee and will be approved prior to any EMSAC subcommittee they vote in. Ad hoc members have no voting authority in the full committee meeting. The number of ad hoc members may not exceed the number of EMSAC sub committee members. **General Session Discussion** Motion to accept the report was seconded and carried. Motion to accept the recommendation with the changes. (including approval of Chair of EMSAC) was seconded and carried.

	Motion to make the recommendation/motion a policy was seconded and carried. 2 nays. Request to address general membership concerns at the next meeting.
LICENSURE	
BOISE FIRE, ALS UPGRADE, NON-TRANSPORT	**Subcommittee Recommendation** Motion made and carried to recommend Bureau approval contingent upon final inspection of personnel, equipment and protocols. **General Session Discussion** Motion to accept report and recommendations seconded and carried.
MINIDOKA COUNTY FIRE, INITIAL BLS, NON-TRANSPORT **Key Points** • Discussion regarding protocols • Staffing – Are they able to respond 24/7 No formal schedule **Discussion** Minidoka: 24/7 – problem throughout the state. The agencies state 24/7 availability on the licensure application but there is no schedule. Philosophically, do we need to hold these agencies to 24/7 response. What is the Bureau's policy on 24/7? Have the ability to provide exemption – in rule. Policy evolution, we will no longer issue those exceptions perpetually. When the agency declares they cannot provide 24/7, do they have a plan to remedy? Did Minidoka state they can not provide 24/7?.No. Stated those that can respond will. Why didn't the subcommittee recommend that they submit a plan for providing 24/7? Need service in the area. Additional service in the area. Still an upgrade to the system. Ambulance service available in the same area. Agency has a dedicated response vehicle. Page 9 said there will be a person assigned to respond 24/7. Commission dictated that someone with an AED will respond.	**Subcommittee Recommendation** Motion made and carried to recommend Bureau approval contingent upon inspection of personnel, equipment and protocols. **General Session Discussion** Motion to accept report and recommendation seconded and carried.
SAGLE FIRE ILS TRANSPORT FYI License modification from ILS Non-Transport to ILS Transport	
SANDPOINT ILS, TRANSPORT FYI License modification from ILS Non-Transport to ILS Transport	

ST. ALPHONSUS-BOISE GROUND COMPONENT FYI	
Adding additional ground ambulances to support flight service operations.	
MEDICAL DIRECTION	
Key Points • The medical direction course will occur on Saturday, October 2 in Post Falls • A team of 7 physicians reviewed and updated course material. • A CD "toolbox" was created for the participants. • The committee reviewed the draft of the BOM Rules. • The committee reviewed a memo from Cathleen Morgan, Attorney Board of Medicine, and suggested changes to the draft rule. • The committee felt there was a fundamental misunderstanding reflected in the memo and rejected all requested changes. **Discussion** Approach we should take for a solution without intending any disrespect to doctors or lawyers. Looking at some of the BOM attorney's suggestions, that there was a misunderstanding of the intent of the draft rules. The current model of promulgating the rules has gone as far as it can and there needs to be a face to face with involved parties - task force members, physicians, and BOM. Need a motion about how to proceed from here. Do we need to meet with the physicians on the Board of Medicine? Formal session. Need to know intent behind the comments. Confusion because issues dealing with out of hospital scenarios, in hospital scenarios, off line and on line medical direction, and supervision are melded. The memo also preserved affiliation language that the task force had decided to eliminate as a certification issue.	**Subcommittee Recommendations** Motion: David Christiansen, MD – make the toolbox CD available to the physicians that participated in the 2002 course The committee suggested a definition of "Hospital" be found in Idaho code and the definition in rule be changed to cite "Hospital – as defined in Idaho Code § (enter cite) The committee suggested replacement of "designated personnel" with designated "physician" in section 201.9 & 201.9.a Motion: Sturkie/McKinnon: EMSAC recommend the draft rules to the BOM for rule making, with the changes identified. **General Session Discussion** Bureau will facilitate formal meeting with key physician members and staff of the BOM members necessary, along with EMSAC medical subcommittee representatives for formal clarification/update regarding current draft version rules seconded and carried. Motion to accept the subcommittee report was seconded and carried.
EDUCATION	
Key Points • Received curricula from ISU developers, waiting for power point and lesson plans. Associated recommended minimum hours to be included with the lesson plans. EMT-I task force meeting will be scheduled after these are received. • CISM training held in Chubbuck last week (Advanced) and Eagle (Basic) in July. Advanced course scheduled for November 29-30 at Eagle. Registration on-line at Institute of Emergency Management.	

• Training Standards Manual reviewed, no major changes were made. Expanded information on guidelines for course, instructor and course coordinator evaluation process and associated consequences for non-compliance to training standards. Appendix B includes list of Adult Instructional Methodology courses approved and commonly available in Idaho.	Motion to accept report was seconded and carried.
GRANT	
Key Points • Dedicated Grant reports reviewed. • Training Grant reports reviewed. Contracts for courses and equipment awarded sent out yesterday. • RAED tentative awards reviewed. AED's will be purchased next month, delivery set for Jan-Feb 05. AED bid awarded to Lifeline – model Defibtech for $932 to include 2 batteries, data cards and pads. Price will be honored for all govt., fire and EMS agencies that purchase on their own. • Thanks to grant sub committee members for participating in the grant review meetings in June and July! Next EMSAC in December we will review Dedicated Grant applications in preparation for Feb application distribution. **Discussion** Isn't there code about purchasing AEDs without a prescription? There was a strike through of the prescription reference on the Idaho Legislative code that passed. Need to advise the recipients of the AEDs about regulatory rules regarding physician oversight, training, notification to local emergency entities, etc. Recent article stated that the frequency of errors on AEDs was 50-60%. People who have had training are sometimes not willing to use the devices. The key is training. There are still success stories about using the AEDs.	Motion to accept the subcommittee report was seconded and carried.